Proposed Licensing Rules and the **Negative Effects on Child Care Programs, Children and Families**

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Proposed Licensing Rules and the **Negative**
Effects on Child Care Programs, Children and Families

*Proposed licensing rules as found on FIA website, dated 1-11-05

R400.5102a Staff Training Requirements

Rule 102a. (1) At least 1 caregiver with current certification in infant, child and adult cpr/first aid shall be on-duty in the center at all times.

(2) At least 50% of caregivers on duty in the center at any time shall possess current first aid certification.

(3) The licensee shall assure that within 1 year of promulgation of these rules current caregivers have completed blood-borne pathogen training.

(4) The licensee shall assure that within 6 months of initial hire each caregiver completes blood-borne pathogen training.

(5) All caregivers shall complete annual training, exclusive of cpr, first aid, and blood borne pathogen training.

(a) Eight clock hours of training shall be completed the first year after the effective date of these rules.

(b) Twelve clock hours of training shall be completed the second year after the effective date of these rules.

(c) Sixteen clock hours of training shall be completed the third year after the effective date of these rules and annually thereafter.

(d) At least 1/2 of the annual hours shall be specific to the age group to which the caregiver is regularly assigned.

(6) Training hours may include participation in any of the following:

(a) Sessions offered by community groups, faith-based organizations, and child care provider associations.

(b) Trainings, workshops, seminars, and conferences on early childhood, child development or child care administration and practices offered by early childhood organizations.

(c) Workshops and courses offered by local or intermediate school districts, colleges, and universities.

(d) In-service trainings.

(e) On-line trainings.

(7) The licensee shall assure that caregivers for infants and toddlers have training that includes information about Safe Sleep and Shaken Baby Syndrome.

(8) A center shall keep on file verification of all professional development education or training, as required by this rule.

Negative Effects on Child Care Programs

Too costly. Real costs of training are not being addressed.

- To train 50% of all staff in CPR and First Aid- really means all staff.
- At the last Child Care Center Rules Advisory Committee meeting a member stated that CPR training from the Red Cross is about $25. Here are the real costs in Lansing- $70 CPR (8hrs) $100 First Aid (12hrs) Blood Borne Pathogens $60 (2hrs) and $23 for materials, totaling $253
- See Attached Rates.

Paying staff for 22 hrs of training x $8.25 per hour $181.50

The real costs for my program- 10 staff $4345. New hires (2)-$896 $5241

Even if there is "free" training available, staff still must be paid hourly wage. Ten staff at an average of $8.25 per hour x 16 hours each $1320

T.E.A.C.H- Teacher Education and Compensation Helps is a professional development program for the Michigan 4C Association funded by FIA. They allow centers to have 4 staff under contract. Centers must pay 10-15% of tuition and books. WE must also provide staff to cover their absences up to 4 hrs per week and a $325 bonus or additional 2% wage increase. I currently have 2 staff doing this and it will cost my program $1700 for 3 semesters.

I "estimate" an additional $2400 to train the other 8 staff.

Estimated Annual Cost **$10, 661**

CPR and First Aid training is good for 2 and 3 years respectively, yet centers in Michigan are expected to train every year.

- Wisconsin requires *current* CPR and first aid training, not annual training
- Minnesota requires first aid training every 3 years and CPR training every 2 years
- Nebraska requires at least 1 staff person who has received first aid training which includes CPR must be on duty at all times, as evidenced by the staffing chart.
- Pennsylvania requires first aid training every 3 years
- Iowa requires a *valid* certificate of training in CPR and first aid training
- Illinois requires that centers shall have on duty 1 staff member who is *currently* certified in first aid and CPR
- Ohio requires that 1 staff member be trained and readily accessible during all operating hours who is *currently* certified in CPR and first aid training. The training is valid for 3 years for first aid and valid for the number of years indicated on the CPR card.
- Indiana requires all staff are trained in first aid every 3 years and 1 staff on duty at all times trained in CPR every 3 years
- Hawaii requires 1 adult caregiver in the facility that has current first aid and CPR certificates. A current certificate means one that has not expired.
- Washington requires that 1 staff person with current first aid and CPR is present with each group of children in the center at all times. First aid and CPR must be updated as required on the card.
- Oklahoma rule states "When children are in care on the center premises or on any center sponsored field trip, staff are present who have current documentation of certification in age appropriate first aid and CPR."
- North Carolina requires first aid trained staff based on the number of children; 1-29 children, 1 trained staff; 30-79 children, 2 trained staff, 80 children and above, 3 trained

staff. In addition, North Carolina requires that 1 person be on duty at all times who is *currently* certified in CPR.

It is unreasonable that CPR and First Aid training are not included in the required training hours.

- Wisconsin rules count the time spent obtaining and renewing this training as part of their required continuing education hours.
- Minnesota rules state that First Aid and CPR training may be counted as in-service training.
- Arizona requires 12 hours of training annually that includes first aid and CPR.

Many centers will "fudge" their training hour documentation, as it translates into real dollars they do not have.

- Pennsylvania requires 6 clock hours of training per year
- Idaho requires 4 hours of ongoing training each year
- Iowa requires 5 clock hours for part time and 10 hours for full time
- Ohio requires 15 hours annually until a maximum of 45 hours are met unless the staff person has completed 60 semester hours with 24 in child development, an Associates degree or a Montessori credential.
- North Carolina pro-rates required training hours for part time employees as follows; 0-10 hours employment = 5 hours of training; 11-20 hours of employment =10 hours of training; 21-30 hours of employment = 15 hours of training; 31-40 = 20 hours of training.
- North Carolina bases required training hours on educational background; Bachelor's degree 5 hours annually, Associates Degree or CDA 8 hours annually.

Negative Effects on Children and Families

When centers need to find tens of thousands of dollars to comply with licensing, they can either raise their rates dramatically or cut services.

Raising rates for low income families means that the gap between what FIA reimburses for child care and the actual cost will increase. Cutting services, such as meals, will affect children of low income families.

If centers cannot find the tens of thousands of dollars that are needed to comply with licensing, then centers will close.

No Child left Behind will not be a reality for many of Michigan's youngest children, when high quality programs close.

*Proposed licensing rules as found on FIA website, dated 1-11-05

R400.5103a Lead Caregiver qualifications; responsibilities

R 400.5103a. Lead caregiver qualifications; responsibilities.

Rule 103a. For the purposes of this rule:

(a) "Child-related fields" include elementary education, child guidance/counseling, child psychology, family studies and social work.

(b) "Child care administration" means child care administration, education administration, or business administration.

(c) A "Child Development Associate Credential" (CDA) means a credential awarded by the Council for Professional Recognition or similar credential approved by the department.

(d) A "Montessori credential" means a credential issued by the Association Montessori Internationale (AMI), American Montessori Society (AMS), or any Montessori teaching training institution recognized by the Montessori Accreditation Council for Teacher Education (MACTE) that meets or exceeds 270 hours of academic training.

(e) Degrees and semester hours shall be from an accredited college or university.

(f) "CEU" means a continuing education unit awarded by a state board of education or an accredited college or university sponsor of continuing education units.

(g) "Hours of experience" means that the experience must be in a licensed or registered facility serving the ages and developmental abilities of the children the caregiver will care for.

(1) The lead caregiver shall:

(a) Oversee the planning, implementation, and evaluation of the classroom program and child assessment.

(b) Be responsible for supervision of caregiving staff for a specific group and for overall care and supervision of children.

(2) At least one lead caregiver shall be assigned to each group of children and shall be present and providing care in the assigned group:

(a) Full time for programs operating less than 6 continuous hours.

(b) Not less than 6 hours per day for programs operating 6 or more continuous hours.

(3) The lead caregiver shall:

(a) Be at least 19 years of age.

(b) Have a high school diploma or ged.

(c) Have current certification in infant, child, and adult cardiopulmonary resuscitation (cpr) and first aid.

(4) A center shall ensure that the qualifications of the lead caregiver meet one of the following:

	Education	Semester Hours/CEU's in a child-related field	Hours of Experience
(a)	Associate's degree in early childhood education or child development		
(b)	Child Development Associate Credential	6 semester hours	520 hours
(c)	Montessori Credential		520 hours
(d)	High school diploma/GED	12 semester hours	1040 hours
(e)	High school diploma/GED	Combination of: 12 semester hours and/or 18 CEU's to equal 180 clock hours	2080 hours
(f)	High school diploma/GED	Combination of: 6 semester hours and/or 9 CEU's to equal 90 clock hours	4160 hours

(5) A lead caregiver for infants and toddlers must have 3 semester hours in infant/toddler development and care practices, from an accredited college or university, or 4.5 ceu's in infant/toddler development and care practices. These hours or ceu's may be a part of the requirements of subrule (4) of this rule.

(6) Within two years from the effective date of these rules the center shall comply with subrule (4) and, if applicable, subrule (5).

(7) A center shall keep on file verification of the education, credential, and experience qualifications of each lead caregiver, as applicable.

Negative Effects on Child Care Programs

This change in rule is devastating as it does not allow for grandfathering of long-term stellar employees.

- New York rules state- "Persons holding positions in a child day care center prior to the effective date of these regulations, who met the qualifications which were in effect at the time they were hired may continue to be employed in such position."
- Illinois rules state, "Persons who were deemed qualified as a child care worker or school age worker prior to January 1, 1985, continue to be deemed qualified as an early childhood teacher or school age worker."
- Indiana rules state that "All early childhood professionals who were employed as a caregiver prior to December 1, 1985 are exempt for the specific educational requirements for this position provided that his or her position continues as an early childhood professional at that child care center."
- Iowa combines education/experience/child development related training with a point system that is more inclusive of long term teachers than what Michigan is proposing.
- North Carolina rules regarding requirements for lead teachers states that "Individuals employed prior to July 1, 1998 are exempted from the requirements of this Rule, as long as they remain employed by the same operator."

Prospective employees that meet the proposed qualifications, are not looking to make child care a long term career, rather a stepping stone to directing or a way earn some money while they are waiting for the school district to call.

The reality is that most teachers in child care cannot make more money by having more education. Quality centers spend 85-92% or more of their budgets on staff salaries.

Why are Montessori trained teachers preferred by the proposed rules?

- Research for this document only found one state, Ohio that gives special consideration for Montessori trained teachers.

Negative Effects on Children and Families

Studies have shown that long term child care providers are essential to the overall development of young children. These changes do not place value on teachers who have dedicated their lives to the care and education of young children.

To attract teachers that meet the proposed rule, centers must raise their rates. Dramatic rate increases will force low income families to choose family and group home care.

*Proposed licensing rules as found on FIA website, dated 1-11-05

R 400.5105c Group size for preschool children.

Rule 105c. (1) A center shall assure the following maximum group size:

(a) For children 3 years of age the maximum group size is 20.

(b) For children 4 years of age the maximum group size is 24.

(2) When there are children of mixed ages in the same room, or well-defined space, the group size shall be determined by the age of the youngest child in the group.

(3) Montessori programs accredited by Association Montessori International (AMI) or American Montessori Society (AMS), may have mixed age groups of children 3 to 6 years of age in the same room, or well-defined space, with a maximum group size of 35.

R 400.5201b Group size for infants; young toddlers; older toddlers.

Rule 201b. (1) A center shall assure that the maximum group size for infants, young toddlers, and older toddlers is 12.

(2) When children who have reached 33 months of age are enrolled in a 3 year old classroom. The group size for 3 year olds shall apply.

Negative Effects on Child Care Programs

It is unjust to give Montessori an exemption while mandating sweeping changes for all other quality programs. Many other programs could have proven their worthiness of an exemption if they would have had an hour of the committee's time.

- Research for this document did not find any other states that give Montessori and any other named program/philosophy special consideration for group sizes or ratios.

Programs have developed business plans, balanced budgets, paid their mortgages and staff based on the numbers of children allowed in each space. When spaces are re-defined by mandatory group sizes, revenue is dramatically affected.

- Washington rules states, "You can request a waiver to group size limitations. If we approve variations to group size limitations, you must maintain the required staff-to-child ratios. Our approval depends on but is not limited to: Lower staff to child ratios; Program structure; Square footage and Staff Qualifications.

Lowering maximum group sizes reduces any possibility a center may have to increase funds to pay for other proposed rules.

When children cannot be mixed together in well-defined spaces, like a gymnasium, programs cannot recognize the full potential of the space and equipment that has been designed for children. Example: On rainy days, we have 4 infants being pushed in the buggy in the

gymnasium. According to rule (2), only 8 other toddlers or 8 other preschoolers could be in the entire gymnasium, making the maximum group size 12.

Programs that provide infant care, usually do so as a service to the public and as a feeder for their toddler classrooms. The proposed changes will cause fewer programs to provide infant care.

It would seem appropriate to grandfather programs that are providing quality care at the current group size. New programs can open with smaller classroom sizes and not have the burden of disenrolling families and decreasing their income base.

Michigan has lower ratios than most states. In comparison, more interaction and higher supervision by teachers and caregivers out weighs required group sizes.

- Arizona's ratios for infants 1:5, 1 year olds 1:6, 2 year olds 1:8, 3 year olds 1:13, 4 year olds 1:15, 5 year olds (not school age) 1:20
- Ohio's ratios for children under 12 months is 1:5 or 2:12 if in the same room, 12 to 18 months 1:6, 18 months to 2 ½ years 1:8, 2 ½-3 years 1:12, 4-5 years 1:14
- Idaho's ratios for children 18 months and younger is 1:6, 18 months to 5 years 1:12
- Illinois' ratios for toddler aged children 15-23 months is 1:5 with a group size of 15, 24 months 1:8 with a group size of 16.
- Indiana's ratios for toddlers-age 2 is 1:5, 30 months to age 3 is 1:7
- Washington's ratios for 12 to 29 months is 1:7, 30 months to 5 years 1:10
- Hawaii's ratios for children age 2 is 1:8, age 3 1:12, age 4 1:16 and 5 and older 1:20
- Oklahoma's ratios for children age 12 to 24 months is 1:6, 2 year olds 1:8, 3 year olds 1:12, 4 and 5 year olds 1:15. Mixed age groups: Infants and older 1:8 groups size of 16, 2 years old and older 1:12 group size of 24, 3 years old and older 1:15 group size of 30
- North Carolina's ratios for children age birth to 12 months 1:5, age 1 to age 2 1:6, age 2 to age 3 1:9, age 4 to age 5 1:13, age 5 to age 6 1:15.
- North Carolina rules have group sizes equivalent to Michigan's proposed rules however; in centers where mixed age groups are care for the ratios increase and as stated "There is no specific group size."

Negative Effects on Children and Families

If maximum group size changes are approved, children will have to be disenrolled from programs to meet the requirements. Fewer spaces, means families will have to look for care in family and group homes.

The only way for programs to recover the lost revenue is to raise rates which put low income families out of the market for quality care and early education.

Children not enrolled in Montessori, will not have the benefit of interacting with older children to gain skill level or experience care-taking activities to build altruism.

There currently are not enough infant and toddler spaces. Reducing the group size will increase the difficulty parents have finding care for their infants and toddlers.

Infant and toddler care is very costly, and most families who receive FIA assistance cannot afford the co-pay. The reduction of spaces forcing tuition increases, low income families will not be able to afford quality infant and toddler care.

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R 400.5204 **Bedding and** ~~S~~sleeping equipment **for infants/toddlers;** seating for staff.

Rule 204. **(1)** ~~Children less than 12 months of age shall sleep in cribs or beds with side rails and firm mattresses. Children 12 months of age and older shall sleep in cribs, beds, or cots. Each sleeping device shall have a washable, waterproof covering and appropriate bedding.~~ **All bedding and equipment shall be in accordance with U.S. Consumer Product Safety Commission standards as approved for the age of the child using the equipment and be clean, comfortable, safe and in good repair.**

(2) A safe crib shall have:

(a) A firm, tight-fitting mattress

(b) No loose, missing, or broken hardware or slats

(c) No more than 2 3/8" between the slats

(d) No corner posts over 1/16" high

(e) No cutout designs in the headboard or footboard

(3) All bedding and sleep equipment shall be cleaned and sanitized before being used by another person.

(4) All bedding shall be washed when soiled or weekly at a minimum.

(5) An infant shall rest or sleep alone in an approved crib or porta-crib. The following provisions shall apply:

(a) A tightly fitted bottom sheet shall cover a firm mattress with no additional padding placed between the sheet and mattress.

(b) The infant's head shall remain uncovered during sleep.

(c) Soft objects, bumper pads, stuffed toys, blankets, and other objects that could smother a child shall not be placed with or under a resting or sleeping infant.

(d) Blankets shall not be draped over cribs or porta-cribs.

(6) Toddlers shall rest or sleep alone in approved cribs, porta-cribs or on approved mats or cots.

7) Car seats, infant seats, swings, bassinets and playpens are not approved sleeping equipment for children.

(8) Infants and toddlers who fall asleep in a space that is not approved for sleeping shall be moved to approved sleep equipment appropriate for their size and age.

(9) Stacking cribs are prohibited.

(a) Centers using stacking cribs prior to the effective date of these rules shall have 2 years from the effective date of these rules to comply.

(b) Stacking cribs for these centers shall be used only for children under seven months of age or not yet standing.

(10) All occupied sleeping equipment shall be spaced no less that 2 feet apart and in such manner that there is a free and direct means of egress.

(11) When sleeping equipment and bedding are stored, sleeping surfaces shall not come in contact with other sleeping surfaces.

(12) ~~(2)~~ **A rocking chair or other** ~~C~~comfortable, adult-sized seating shall be provided for ~~1/2~~ **50%** of the caregiving staff on duty **who are providing infant and toddler care.**

Negative Effects on Child Care Programs

Prohibiting stacking cribs would take away a huge amount of play space for infants. Three high quality programs in the Lansing area have been using stacking cribs for a combined total of 43 years without incident or accident. Programs that have demonstrated proper and safe use of stacking cribs should be grandfathered.

- Nebraska rule states, "Stacked cribs are not used for infant sleeping/napping in centers initially licensed after January 1, 1983.

The rationale that stacking cribs limit visual stimulation is only supported when programs use cribs as play areas. No crib, stacking or free standing should be used except for sleeping. Visual stimulation should be occurring during awake periods on open spaces where infants can explore or observe their surroundings.

The rationale that stacking cribs with no space between them causes infectious disease is not based in fact. Infants spend more time side by side, crawling over one another and breathing the same air outside of the cribs than in them.

Stacking cribs are the same size as free standing porta cribs. Children are less likely to fall out of a stacking crib than they are to fall out of a free standing crib or porta crib. Infants who are crawling and pulling up are more likely to injure themselves on the legs of free standing cribs, than on any surface of a stacking crib.

- A lawsuit against the Evenflo Company was settled with a $2.6 million dollar settlement paid to the family of an 8 month old infant. The Happy Camper porta crib's hinge on the top rail collapsed, crushing the infant boy's chest. The Happy Camper porta crib and other similar porta cribs have been the cause of 15 infant deaths in the United States.
  Source- www. BeaslyAllen.com

Any equipment improperly secured, (cabinets, shelving, changing tables) would be dangerous. Programs that have used stacking cribs without incident or accident should be exempt.

- Iowa allows stacking cribs and any other crib like furniture that meets the current standards from the Consumer Product Safety Commission and the American Society for Testing Materials.
- North Carolina University at Greenville has developed a rating scale (ITERS) Infant Toddler Environment Rating Scale which states under infant/toddler safety practices- "*Stacking cribs* should be examined and observed, as all other cribs are for safety. For example, there should be safe distance between slats, if children can pull up they should have room to stand, there should be no danger of a child's falling out of a crib, and cribs should be easily opened by adults."

Negative Effects on Children and Families

In many centers, the elimination of stacking cribs would mean the elimination of infant spaces as the current classrooms are not large enough to put free standing cribs and the other equipment needed.

In our program, the infants would lose 50% of their open floor space, where they learn to lift their heads, sit alone, roll over, crawl, pull up and eventually walk.

*Proposed licensing rules as found on FIA website, dated 1-11-05

R 400.5202 Primary care.

Rule 202. (1) For the purposes of this rule, primary care means:

(a) ~~R 400.5202 (4) (a)~~ Continuity of a ~~1~~ relationship so that a child has as few primary caregivers, including substitute caregivers, as possible during any given day, within any given week, and over an extended period of time.

(b) ~~R 400.5202 (4) (b)~~ Continuity of care to allow children and their primary caregiver to develop nurturing relationships over time.

(c) ~~R 400.5202 (4) (c)~~ Appropriate social-emotional interaction, including but not limited to smiling, holding, talking to, rocking, cuddling, eye contact, interacting with the child during routines and play activities, and providing guidance that helps the child develop social skills and emotional well-being.

~~R 400.5202 (4)~~ (2) A center shall ~~arrange its staffing pattern~~ implement a primary care system so that each ~~child between the ages of birth and 3 years~~ infant, young toddler, and older toddler has a primary caregiver ~~to provide all of the following:~~.

(3) Each child shall have no more than 2 primary caregivers within a 12 hour period of any given day and no more than 4 primary caregivers in a week. For centers operating less than 24 hours a day, an exception may occur during the first hour after the center opens and the hour prior to closing.

(4) Information regarding a child's food, health, and temperament shall be shared daily between caregivers when more than 1 primary caregiver is assigned to any infant, young toddler, or older toddler.

(5) Primary caregiving assignments shall be documented and provided to parents.

(6) An exception to R 400.5202 may be made when the center is transporting children and is in compliance with R 400.5611(1) and (2).

Negative Effects on Child Care Programs

The changes to no more than 2 care givers in a day, is a wonderful goal, but to make it a rule for everyday operation is unreasonable.

- For example: a child may have a primary caregiver in the morning, then another person who comes in to cover breaks (naptime) and then an afternoon caregiver comes in for the rest of the day.

The change to no more than 4 caregivers in a week would be very difficult while also trying to comply with training requirements that would take teachers and caregivers away from the classrooms.

- Indiana's rule states, "Centers shall make a reasonable effort to provide continuity of care under 30 months of age."
- Oklahoma's rule states, "Groups are required to have assigned staff and be recognizable by both staff and the children"
- North Carolina's rule states. "A caregiver or a team of caregivers shall be assigned to each infant or toddler as the primary caregiver(s) who shall be responsible for care the majority of the time."